

Coordination of California Workers' Compensation and State Disability Insurance Benefits: A Legal Analysis

(PART-A INJURED WORKERS ANALYSIS)

March 2, 2026

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COORDINATION OF CALIFORNIA WORKERS' COMPENSATION AND STATE DISABILITY INSURANCE BENEFITS

This report explains how California's two major disability benefit programs—workers' compensation and State Disability Insurance (SDI)—work together when you are injured. These programs have strict rules that prevent you from collecting full benefits from both at the same time. Understanding these rules helps you avoid overpayments, maximize your benefits, and protect your rights.

Part 1: Overview of the Two Benefit Programs

This section introduces the two disability programs available to California workers and explains why coordination between them matters.

What Is Workers' Compensation?

Workers' compensation is a benefit system that pays you when you are hurt or become sick because of your job. It is a "no-fault" system, meaning you do not need to prove your employer did anything wrong—you only need to show the injury or illness happened because of your work. In exchange, you generally cannot sue your employer in civil court for the same injury. Workers' compensation is established under the California Labor Code, Division 4 (commencing with § 3200) (<https://www.calhr.ca.gov/workers-compensation-preview>).

Workers' compensation provides three main types of help:

- Wage replacement — You receive two-thirds (66.67%) of your average weekly earnings while you cannot work, subject to minimum and maximum limits set each year.
- Medical treatment — Your employer's insurance pays for all reasonable and necessary medical care related to your work injury. You pay nothing out of pocket.
- Permanent disability payments — If your injury causes lasting problems, you receive additional payments based on how much the injury affects your ability to work in the future.

For 2026, the minimum weekly temporary total disability (TTD) payment is \$264.61, and the maximum is \$1,764.11 per week. These amounts are set by the Division of Workers' Compensation (DWC) (<https://www.dir.ca.gov/DIRNews/2025/2025-116.html>) and change every year based on the State Average Weekly Wage (SAWW).

What Is State Disability Insurance?

State Disability Insurance (SDI) is a separate program run by the Employment Development Department (EDD). SDI pays you when you cannot work because of a non-work-related illness, injury, pregnancy, or other medical condition. Unlike workers' compensation, SDI does not cover work injuries and does not pay for medical treatment—it only replaces part of your lost wages. SDI is established under the California Unemployment Insurance Code (<https://edd.ca.gov/en/disability/>).

SDI benefits are funded through payroll deductions from your paycheck (1.3% of your gross wages as of 2025). You may qualify if you earned at least \$300 during your base period (a specific 12-month window before your claim) and a doctor certifies you cannot do your regular work.

SDI pays between 70% and 90% of your average weekly wages, depending on your income level, up to a maximum of \$1,765 per week for 2025–2026. You can receive SDI for up to 52 weeks per claim. Benefit amounts are calculated using your earnings from the highest-earning quarter of your base period (<https://edd.ca.gov/en/disability/CalculatingDIBenefitPaymentAmounts/>).

Why Coordination Matters

The most important rule is: you generally cannot receive full benefits from both workers' compensation and SDI at the same time for the same injury and time period. This is called the "no double-dipping" rule. If you receive benefits from both programs when you should not, you may have to pay money back, and you could face penalties. The coordination rules are found in Cal. Lab. Code § 4664 (<https://www.sullivanattorneys.com/blog/understanding-accumulation-of-permanent-disability-under-lc-4664>)

and EDD administrative guidance on workers' compensation and disability benefits (<https://edd.ca.gov/en/disability/EmployerWorkersCompensation/>).

Part 2: Legal Framework and Statutory Authority

This section explains the laws that create and govern both programs, including the rules for how benefits are coordinated.

Workers' Compensation Statutes

California's workers' compensation laws are found primarily in the California Labor Code, Division 4 (starting at § 3200) and Division 5 (starting at § 6300). Here are the key provisions:

- Cal. Lab. Code § 3200 (<https://www.calhr.ca.gov/workers-compensation-preview>) establishes the no-fault principle: you receive benefits for any injury arising out of and during the course of your employment, regardless of who was at fault.
- Cal. Lab. Code § 4650 (<https://employeesfirstlaborlaw.com/labor-code-%C2%A74650-timing-of-temporary-disability-payments/>) requires your employer's insurance to begin temporary disability payments no later than 14 days after learning of your injury and disability, and to continue payments at least every two weeks.
- Cal. Lab. Code §§ 4660–4664 (<https://www.dir.ca.gov/dwc/workerscompensationbenefits.htm>) govern permanent disability ratings. These sections establish how doctors evaluate your lasting impairment using the AMA Guides to the Evaluation of Permanent Impairment (5th Edition) and how that rating converts to a disability percentage.
- Cal. Lab. Code § 4664(c)(1) (<https://www.sullivanattorneys.com/blog/understanding-accumulation-of-permanent-disability-under-lc-4664>) limits the total permanent disability awards for any one body region to 100% over your lifetime, unless your injury is conclusively presumed to be totally disabling under § 4662.
- Cal. Lab. Code § 5400 (<https://www.invictuslawpc.com/workers-comp-claim-filing-time-limits/>) requires you to report your injury to your employer within 30 days of learning about the work connection.
- Cal. Lab. Code § 5405 (<https://www.invictuslawpc.com/workers-comp-claim-filing-time-limits/>) sets a one-year statute of limitations (deadline) to file a workers' compensation claim from the date of injury.

State Disability Insurance Statutes

SDI operates under the California Unemployment Insurance Code (commencing at § 3200 et seq.). Key rules include:

- You must have earned at least \$300 in wages during the base period and paid SDI taxes on those wages. See EDD Contribution Rates and Benefit Amounts (<https://edd.ca.gov/en/disability/ContributionRatesandBenefitAmounts/>).
- A licensed physician must certify you cannot perform your normal work duties.
- Your medical condition must be expected to last at least eight consecutive calendar days (one day for pregnancy or hospitalization).
- You must intend to return to work when your condition improves.

The Coordination and Offset Laws

Several laws work together to prevent you from receiving duplicate benefits:

- Cal. Lab. Code § 2629.1(f) (<https://www.lflm.com/news-knowledge/temporary-disability-primer-common-issues-and-pitfalls-in-calculating-average-weekly-wage/>) requires your employer to reimburse EDD within 60 days once a workers' compensation claim is accepted or a final award is issued, for any SDI benefits paid while the workers' compensation claim was pending.
- EDD administrative guidance establishes that SDI generally does not apply (<https://edd.ca.gov/en/disability/EmployerWorkersCompensation/>) when you are receiving workers' compensation for the same condition during the same time period.
- When SDI is paid while a workers' compensation claim is under investigation, EDD files a statutory lien (a legal claim for repayment) against any future workers' compensation settlement or award.

Important: If your workers' compensation claim is ultimately denied, any SDI benefits you received remain yours and no repayment is required.

Social Security Disability Insurance Offset

If you also receive federal Social Security Disability Insurance (SSDI), a separate offset rule applies under 42 U.S.C. § 424a (<https://www.ssa.gov/policy/docs/ssb/v65n4/v65n4p3.html>). This rule says your combined workers' compensation and SSDI benefits cannot exceed 80% of your average current earnings (ACE). The Social Security Administration reduces your SSDI payment—not your workers' compensation—to stay within this limit.

Part 3: How Benefits Are Calculated

This section explains the formulas used to determine how much you receive from each program.

Average Weekly Wage for Workers' Compensation

Your average weekly wage (AWW) is the starting point for calculating workers' compensation benefits. The AWW is determined under Cal. Lab. Code § 4453 (<https://royanglaw.com/how-is-workers-comp-calculated/>) and Cal. Code Regs. tit. 8, § 10101.1 (<https://www.sullivanattorneys.com/hubfs/docs/Resources/AWW-Calculation-Guide-2024.pdf>) using one of four methods:

- Method 1 — Regular full-time work: Your daily wage multiplied by the number of working days per week. Example: \$25/hour × 8 hours × 5 days = \$1,000/week.
- Method 2 — Multiple jobs at the same time: Earnings from all employers are included, but secondary employer wages are "stepped down" to the rate paid by the employer where you were injured. This rule can significantly lower your AWW.
- Method 3 — Irregular earnings (commission, seasonal, piecework): Your total earnings over the 52 weeks before injury, divided by 52.
- Method 4 — Catch-all: When no other method fairly applies, the claims administrator must document all factors and calculate an AWW that is fair under the circumstances.

Temporary Disability Benefit Calculation

Temporary disability (TD) benefits equal two-thirds of your AWW, subject to annual minimum and maximum rates:

- 2025 rates: Minimum \$252.03/week; Maximum \$1,680.29/week
- 2026 rates: Minimum \$264.61/week; Maximum \$1,764.11/week

These rates reflect a 4.988% increase in the SAWW (<https://www.dir.ca.gov/DIRNews/2025/2025-116.html>) from 2024 to 2025. If you receive TD payments for 24 months or more after your injury, Cal. Lab. Code § 4661.5 (<https://www.sullivanattorneys.com/hubfs/docs/Resources/AWW-Calculation-Guide-2024.pdf>) requires your benefits to be recalculated using the current year's rates, as long as this does not lower your payment.

There are two types of temporary disability:

- Temporary Total Disability (TTD): Paid when you cannot work at all due to your injury. Limited to 104 weeks within five years of the injury date (up to 240 weeks for severe injuries).
- Temporary Partial Disability (TPD): Paid when you return to work but earn less than before because of work restrictions. TPD equals two-thirds of the difference between your pre-injury and current earnings.

Permanent Disability Benefit Calculation

Permanent disability (PD) benefits are calculated after you reach Maximum Medical Improvement (MMI), also called Permanent and Stationary (P&S)—the point when further treatment is unlikely to produce significant improvement. PD benefits use a three-step process (<https://www.dir.ca.gov/dwc/workerscompensationbenefits.htm>):

1. A doctor assigns a Whole Person Impairment (WPI) rating using the AMA Guides, 5th Edition.
2. The WPI rating is multiplied by 1.4 (for injuries on or after January 1, 2013) to account for lost future earning capacity.
3. The result is adjusted for your age and occupation using the Permanent Disability Rating Schedule (PDRS) to produce a final disability percentage (1%–100%).

Weekly PD benefits range from a minimum of \$160/week to a maximum of \$290/week (for injuries on or after January 1, 2014). Ratings of 70%–99% also qualify you for a life pension that continues until death. A rating of

100% qualifies you for Permanent Total Disability (PTD), which provides lifetime wage replacement (<https://employeesfirstlaborlaw.com/permanent-total-disability-in-california-workers-comp-lifetime-benefits-guide/>) at the TTD rate with annual cost-of-living increases.

SDI Benefit Calculation

SDI benefits are based on your earnings during the highest-earning quarter of your base period. The EDD calculation formula (<https://edd.ca.gov/en/disability/CalculatingDIBenefitPaymentAmounts/>) works as follows for 2025:

- Annual earnings \$2,890–\$65,119: About 90% of average weekly wages
- Annual earnings over \$83,725: 70% of average weekly wages, up to the \$1,765 weekly maximum
- Minimum benefit: \$50/week
- Maximum duration: 52 weeks per claim

Part 4: Coordination Rules and the Offset System

This section explains exactly how benefits from workers' compensation and SDI interact when you qualify for both.

The No Double-Dipping Rule

You cannot receive full wage replacement from both workers' compensation and SDI for the same injury and the same time period. This rule exists because both programs are designed to replace lost wages, and receiving both would give you more than your actual lost wages. See EDD guidance on workers' compensation and disability benefits (<https://edd.ca.gov/en/disability/EmployerWorkersCompensation/>).

Here is how the coordination works in practice:

- Workers' compensation is active: SDI does not apply. Workers' compensation is the primary payor for work-related injuries.
- Workers' compensation is delayed or under investigation: SDI may be paid as a bridge during the delay period (up to 90 days while the insurer investigates).
- Workers' compensation is denied: SDI benefits remain yours with no repayment obligation.
- Workers' compensation is accepted after SDI was paid: EDD files a lien to recover SDI amounts from your workers' compensation settlement or award.

The SDI Lien and Recovery

When SDI pays you while your workers' compensation claim is pending, EDD gains a legal right to be repaid once workers' compensation resolves your claim. Under Cal. Lab. Code § 2629.1(f) (<https://www.iflm.com/news-knowledge/temporary-disability-primer-common-issues-and-pitfalls-in-calculating-average-weekly-wage/>), your employer must reimburse EDD within 60 days of accepting your claim or receiving a final award. This repayment reduces the net amount you receive from workers' compensation.

Example: You received \$5,000 in SDI while your workers' compensation claim was investigated. Workers' compensation is accepted and you receive a \$30,000 settlement. The EDD lien of \$5,000 is deducted, and you receive \$25,000 net.

The Supplemental Payment Exception

There is an important exception: if your SDI weekly rate is higher than your workers' compensation TTD rate, you may receive a supplemental SDI payment equal to the difference between the two rates. This means you receive your full workers' compensation benefit plus a top-up from SDI to reach the higher SDI amount. See EDD coordination guidance (<https://edd.ca.gov/en/disability/EmployerWorkersCompensation/>) and additional analysis of concurrent benefits (<https://lawnjh.com/can-you-collect-workers-comp-and-short-term-disability-at-the-same-time/>).

Example: Your TTD is \$400/week, and your SDI rate is \$600/week. You receive \$400 from workers' compensation plus \$200 from SDI, totaling \$600/week.

This exception is most relevant for lower-wage workers whose TTD falls near the statutory minimum while their SDI rate is calculated at 90% of wages.

SSDI Offset Calculation

If you receive both workers' compensation and SSDI, the Social Security Administration applies an 80% offset (<https://www.ssa.gov/policy/docs/ssb/v65n4/v65n4p3.html>) under 42 U.S.C. § 424a (<https://www.ssa.gov/policy/docs/ssb/v65n4/v65n4p3.html>):

Example:

- Pre-disability monthly earnings: \$5,000
- 80% cap: \$4,000
- Workers' compensation monthly benefit: \$2,500
- SSDI monthly benefit (before offset): \$2,200
- Combined total (\$4,700) exceeds the \$4,000 cap by \$700
- SSDI is reduced by \$700 to \$1,500
- Final combined benefits: \$2,500 + \$1,500 = \$4,000

Part 5: Filing Strategy and Timing

This section explains when and how to file for each benefit to protect your rights and maximize your total recovery.

Step 1: Report Your Work Injury Immediately

If there is any chance your injury is work-related, report it to your employer right away, in writing. This satisfies the 30-day notice requirement under Cal. Lab. Code § 5400 (<https://www.invictuslawpc.com/workers-comp-claim-filing-time-limits/>) and triggers your employer's obligations to:

- Investigate the claim (they have up to 90 days)
- Provide up to \$10,000 in medical treatment while the claim is under investigation
- Begin TTD payments within 14 days under Cal. Lab. Code § 4650 (<https://employeesfirstlaborlaw.com/labor-code-%C2%A74650-timing-of-temporary-disability-payments/>)

Important: You must file your workers' compensation claim within one year of the date of injury under Cal. Lab. Code § 5405 (<https://www.hanningsacchetto.com/blog-post/what-is-the-statute-of-limitations-for-filing-a-california-workers-compensation-claim/>). Missing this deadline can permanently bar your claim.

Step 2: Consider Filing for SDI if There Is a Delay

If your workers' compensation claim is delayed or the work-relatedness is genuinely uncertain, you may also file for SDI (<https://edd.ca.gov/en/disability>) to receive wage replacement during the investigation period. Key points to remember:

- SDI benefits are not retroactive before your claim start date, so file promptly.
- If workers' compensation is later accepted, any SDI you received will be repaid through the EDD lien.
- If workers' compensation is denied, your SDI benefits remain yours.
- When filing for SDI, disclose any pending workers' compensation claim so EDD can coordinate benefits properly.

Step 3: Coordinate Around Maximum Medical Improvement

When your doctor declares you Permanent and Stationary (P&S), several things happen at once:

- TTD benefits stop (you are no longer "temporarily" disabled)
- The permanent disability evaluation process begins
- SDI must stop if workers' compensation has accepted your claim
- Eligibility for the Supplemental Job Displacement Benefit (SJDB) voucher is determined

The SJDB voucher is worth up to \$6,000 for retraining or education if you cannot return to your usual job and your employer does not offer suitable alternative work within 60 days. See DWC Return to Work guidance (<https://www.dir.ca.gov/chswc/returntoworkpage1.html>). You may also qualify for the Return-to-Work Supplement Program (RTWSP) (<https://www.dir.ca.gov/rtwsp/rtwsp.html>), a one-time \$5,000 payment.

Step 4: Resolve the EDD Lien Before Settlement

Before settling your workers' compensation claim, your attorney should obtain an EDD lien statement showing the exact amount of SDI benefits paid. The settlement document should clearly show:

- The gross award amount (before lien deduction)
- The EDD lien amount
- The net award paid to you
- The separate payment to EDD

This protects you from post-settlement disputes and ensures compliance with Cal. Lab. Code § 2629.1(f) (<https://www.iflm.com/news-knowledge/temporary-disability-primer-common-issues-and-pitfalls-in-calculating-average-weekly-wage/>).

Part 6: Overpayments, Recovery, and Repayment

This section explains what happens if you are paid too much and how to handle overpayment situations.

How Overpayments Happen

Overpayments can occur in several ways:

- Duplicate payments: You receive full benefits from both workers' compensation and SDI for the same period when only one should pay.
- Calculation errors: The claims administrator or EDD uses incorrect wage information.
- Continued payments after returning to work: TTD continues after you resume full-time employment.
- Coordination failures: Neither program reduces your benefit to account for the other.

EDD Overpayment Process

When EDD determines you were overpaid (<https://edd.ca.gov/en/claims/Benefit-Overpayments/>), it sends a "Notice of Potential Overpayment" along with a Personal Financial Statement form. You should:

1. Review the notice carefully to understand the amount and reason for the overpayment.
2. Complete and return the Personal Financial Statement if you want to request a waiver (forgiveness of the overpayment). EDD grants waivers only if repayment would cause "extraordinary hardship."
3. If not waived, repay the overpayment through lump sum, future benefit offset (25% of future benefits withheld), tax refund offset, or other methods described in the notice.

Critical: If you believe the overpayment determination is wrong, you must file a written appeal within 30 days of the notice's mailing date. An Administrative Law Judge (ALJ) at the California Unemployment Insurance Appeals Board (CUIAB) will review your appeal. See EDD Benefit Overpayment FAQs (<https://edd.ca.gov/en/claims/FAQ-Benefit-Overpayments/>).

Workers' Compensation Overpayment Process

If your workers' compensation claims administrator discovers an overpayment, it may stop payments or file a "Petition for Credit for Overpayment" with the Workers' Compensation Appeals Board (WCAB) to reduce future benefits by the overpaid amount. You can contest the overpayment at a hearing before a Workers' Compensation Judge (WCJ).

Penalties for Fraud

If you intentionally misrepresent your earnings, work status, or medical condition to receive duplicate benefits:

- EDD imposes a penalty of 30% of the fraud overpayment amount, on top of full repayment. See EDD Benefit Overpayments and Penalties (<https://edd.ca.gov/en/claims/Benefit-Overpayments/>).
- Workers' compensation fraud may result in criminal prosecution for perjury or fraud under California Penal Code §§ 118, 148, or 550.

Important: Always report your benefits honestly to both programs. Transparent reporting is the best way to avoid overpayments and penalties.

Part 7: Appeals and Dispute Resolution

This section explains your rights if you disagree with a decision about your benefits.

Appealing an EDD Decision

If EDD denies your SDI claim, reduces your benefits, or finds an overpayment, you can appeal:

1. File a written appeal within 30 days of the notice's mailing date.
2. An ALJ at CUIAB (<https://edd.ca.gov/en/claims/FAQ-Benefit-Overpayments/>) will hold a hearing (usually by phone or video as of 2026).
3. You must prove the EDD's decision is incorrect by presenting evidence of your earnings, work status, or medical condition.
4. If you lose, you may appeal to the full CUIAB board within 30 days, though CUIAB reviews only legal questions, not factual disputes.
5. If you lose at CUIAB, you may seek judicial review in superior court through a writ of mandate (a court order directing the agency to reconsider).

Appealing a Workers' Compensation Decision

If a WCJ makes a decision you disagree with:

1. File a Petition for Reconsideration with the WCAB (<https://www.dir.ca.gov/wcab/wcab.htm>) within 20 working days of the decision.
2. The WCAB may affirm, modify, or reverse the WCJ's decision.
3. If you disagree with the WCAB's decision, file a Petition for Writ of Review with the California Court of Appeal within 30 days.
4. The Court of Appeal reviews for legal errors only and does not revisit factual findings unless they lack substantial evidence. See DWC claim denial guidance (<https://www.dir.ca.gov/dwc/myclaimwasdenied.htm>).

Independent Medical Review for Treatment Disputes

If your workers' compensation claims administrator denies a medical treatment request through utilization review (UR), you have the right to request Independent Medical Review (IMR) through the DWC (https://www.dir.ca.gov/dwc/IMR/IMR_FAQs.htm):

- File DWC Form IMR-1 within 30 days of the UR decision.
- An independent physician reviews the medical records and decides whether the treatment is medically necessary.
- If the reviewer approves treatment, the claims administrator must authorize it within five business days.
- If you disagree with the IMR result, you may petition the WCAB within 30 days, but only on limited grounds (conflict of interest, bias, fraud, or clear factual error). See DWC IMR information (<https://www.dir.ca.gov/dwc/imr.htm>) and utilization review dispute resolution regulations at Cal. Code Regs. tit. 8, § 9792.10.1 (<https://www.dir.ca.gov/t8/9792101.html>).

Note: Updated utilization review regulations take effect April 1, 2026, imposing faster timelines and stricter documentation standards for treatment decisions. See *Pacific Workers analysis of UR changes* (<https://www.pacificworkers.com/blog/2026/january/utilization-review-changes-effective-april-1-2026>).

Part 8: Medical and Vocational Evaluations

This section explains the medical and vocational processes that determine your benefits.

Qualified Medical Evaluators

When there is a dispute about your medical condition, a Qualified Medical Evaluator (QME) conducts an independent evaluation. A QME is a state-certified physician who meets special education and licensing requirements (<https://www.dir.ca.gov/dwc/medicalunit/faqiw.html>). The QME process works as follows:

- A panel of three QMEs is randomly selected by the DWC Medical Unit based on your injury type and location.

- You choose one QME from the panel within 10 days. If you do not choose, the claims administrator may choose for you.
- The QME reviews your medical records, examines you, and writes a report on causation, impairment level, work restrictions, and future medical needs.
- See DWC QME panel selection instructions at Cal. Code Regs. tit. 8, § 108 (<https://www.dir.ca.gov/t8/108.html>).

The QME's report is a key piece of evidence in determining your permanent disability rating and your right to future medical care.

Medical Provider Networks

If your employer has a Medical Provider Network (MPN), you must initially treat within that network. MPNs must meet access standards including at least three physicians in each specialty within 30 minutes or 15 miles of your workplace (<https://www.dir.ca.gov/dwc/medicalcare.htm>). After the first appointment, you may switch to another MPN doctor. If no MPN exists, you may choose any available physician after the first 30 days.

For SDI, you choose your own doctor without any network restrictions.

Vocational Rehabilitation and Job Displacement

If you reach MMI and cannot return to your usual job, you may qualify for:

- SJDB voucher — Up to \$6,000 for education and retraining at state-approved schools. The voucher must be used within two years of issuance or five years of injury, whichever is later. See DWC Return to Work page (<https://www.dir.ca.gov/chswc/returntoworkpage1.html>).
- Return-to-Work Supplement Program — A one-time \$5,000 payment (<https://www.dir.ca.gov/rtwsp/rtwsp.html>) for workers with low permanent disability ratings relative to their actual earnings loss. You must apply through the online RTWSP portal within one year of SJDB voucher issuance.

Part 9: Other Benefit Interactions

This section covers how workers' compensation and SDI interact with other programs you may be eligible for.

Medicare and Workers' Compensation Settlements

If you receive SSDI and become eligible for Medicare, Medicare may become responsible for your medical care if your workers' compensation settlement closes your right to future medical treatment. If your settlement includes a lump sum for future medical costs (called a Compromise and Release), a portion may need to be placed in a Medicare Set-Aside (MSA) account to pay for future injury-related care before Medicare begins paying. See the DWC Compromise and Release form (<https://www.dir.ca.gov/dwc/eam/SampleFiles/Compromise%20and%20Release.pdf>) and SSA guidance on California workers' compensation (<https://secure.ssa.gov/poms.nsf/lnx/0452120030>).

Unemployment Insurance

You generally cannot receive TTD and Unemployment Insurance (UI) at the same time because TTD requires you to be unable to work, while UI requires you to be able and available for work. However, if you work part-time and receive TPD, you may qualify for partial UI benefits if your total earnings fall below the threshold. See EDD coordination guidance (<https://edd.ca.gov/en/disability/EmployerWorkersCompensation/>).

Employer-Provided Short-Term Disability

If your employer provides private short-term disability (STD) insurance, the policy typically reduces your STD payment by the amount of workers' compensation you receive, so your combined total does not exceed the full benefit amount. Review your employer's policy carefully for specific offset provisions.

Part 10: Recent Legal Developments (As of March 2026)

This section summarizes recent changes that may affect your benefits.

2026 TTD Rate Increase

Effective January 1, 2026, TTD rates increased based on a 4.988% SAWW increase. The new minimum is \$264.61/week and the maximum is \$1,764.11/week. This affects all workers currently receiving TTD and all new claims. See DWC announcement (<https://www.dir.ca.gov/DIRNews/2025/2025-116.html>) and Keenan briefing (<https://www.keenan.com/knowledge-center/news-and-insights/briefings/workers-compensation-benefits-increase-effective-january-1-2026/>).

Utilization Review Changes (Effective April 1, 2026)

Updated regulations impose faster deadlines and stricter documentation requirements (<https://www.pacificworkers.com/blog/2026/january/utilization-review-changes-effective-april-1-2026/>) for approving or denying medical treatment requests. Keep copies of all treatment requests and responses. If treatment is delayed, this may justify filing for SDI as a bridge while the workers' compensation dispute is resolved.

Apportionment Developments

In *Stranak v. City of Los Angeles*, 2024 Cal. Wrk. Comp. P.D. LEXIS 179, the WCAB clarified that when a disability affects multiple body systems under Cal. Lab. Code § 4664(c)(1) (<https://www.sullivanattorneys.com/blog/understanding-accumulation-of-permanent-disability-under-lc-4664>), it should be assigned to the body system generating the highest rating, and the employer bears the burden of proving apportionment.

Proposed Legislation: SB 555

Senate Bill 555 (introduced March 27, 2025, by Senator Anna M. Caballero) would extend annual cost-of-living adjustments to Permanent Partial Disability benefits. As of March 2026, this bill has not been enacted. If it passes, it could change the calculation for whether to settle PPD claims or accept ongoing payments.

Part 11: Northern California Procedures

This section covers local procedures relevant to workers in the San Francisco Bay Area and Northern California.

DWC District Offices

Northern California workers' compensation cases are handled through DWC offices in San Francisco (100 Montgomery Street, Suite 800, and 630 Sansome Street, 4th Floor) and Concord (1855 Gateway Blvd., Suite 850). See the DWC Contact page (<https://www.dir.ca.gov/dwc/contactdwc.htm>) for hours and directions.

Hearing Procedures

San Francisco WCJs generally require detailed written motions, favor early continuances for evidence gathering, and hold mandatory settlement conferences before trial. Remote appearances by video remain available for hearings and conferences as of 2026. However, in-person QME examinations are still required in most cases.

Federal Court Review

The United States District Court for the Northern District of California (based in San Francisco) may hear challenges to WCAB decisions or EDD overpayment determinations in narrow circumstances—typically when constitutional rights or federal law questions are involved. You must generally exhaust all state administrative remedies before seeking federal court review. See DWC administrative penalty regulations at Cal. Code Regs. tit. 8, § 9792.12 (https://www.dir.ca.gov/t8/9792_12.html).

Part 12: Risk Assessment and Practical Guidance

This section provides practical advice for making decisions about your benefits.

Key Risk Factors

- Uncertain work-relatedness (Medium-to-High Risk): If you are unsure whether your injury is work-related, report it to your employer in writing immediately. The cost of reporting is minimal, but failing to report can permanently bar your workers' compensation claim.
- Benefit rate differences (Low-to-Medium Risk): Calculate both your workers' compensation and SDI rates using 2026 figures before filing. For some income levels, SDI's 90% rate exceeds workers' compensation's 66.67% rate.
- Medical coverage gaps (Medium Risk): SDI does not pay for medical treatment. If you file for SDI first and later discover the injury is work-related, you may have medical bills that neither program covers during the gap.

Recommended Steps

1. Report any potentially work-related injury to your employer immediately, in writing.
2. File your workers' compensation claim within one year of the injury date.
3. If workers' compensation is delayed, consider filing for SDI to bridge the gap.
4. Disclose all benefits to both programs to avoid overpayments.
5. Request regular benefit statements from both the claims administrator and EDD.
6. Before settling, obtain the EDD lien amount and ensure the settlement document accounts for it.
7. Consult an attorney before making decisions about settlement structure, especially if you also receive SSDI or Medicare.

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Coordination of California Workers' Compensation and State Disability Insurance Benefits: A Legal Analysis

(PART-B LEGAL ANALYSIS)

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I. EXECUTIVE SUMMARY

California's workers' compensation system and State Disability Insurance program represent two distinct wage-replacement mechanisms that injured workers may potentially access, yet these systems contain overlapping eligibility criteria and strict coordination requirements designed to prevent simultaneous receipt of duplicate benefits for the same period of disability. When an injured worker sustains a work-related injury or illness, workers' compensation provides comprehensive wage replacement (calculated as two-thirds of average weekly earnings subject to statutory minimums and maximums), medical treatment authorization, and permanent disability compensation based on whole-person impairment ratings[1][10][10]. By contrast, State Disability Insurance, administered by the Employment Development Department (EDD), provides short-term wage replacement benefits for non-work-related illness, injury, pregnancy, or family care leave, calculated as seventy to ninety percent of average weekly wages earned during the base period, up to a 2026 maximum of \$1,765 weekly[6][15]. The fundamental legal principle governing these programs is that injured workers generally cannot receive full benefits from both systems simultaneously for the same condition and time period; rather, California Labor Code Section 4664 and related coordination provisions establish offset mechanisms whereby receipt of one benefit reduces or eliminates eligibility for the other, subject to exceptions when SDI supplements workers' compensation during delays or when SDI rates exceed temporary disability rates[10][10][10].

This report addresses the complex interaction between these two major disability programs by examining statutory authority, current regulatory guidance, benefit calculation methodologies specific to both Northern California and statewide practice, strategic considerations for injured workers and their counsel, and remedial pathways when disputes arise. The current legal landscape as of March 2026 reflects recent clarifications regarding utilization review procedures (effective April 1, 2026)[40], updated temporary total disability rates (effective January 1, 2026)[34][37], and ongoing administrative guidance from the Division of Workers' Compensation regarding independent medical review and benefit coordination[45]. Injured workers navigating these systems face medium-level risk of unintended overpayment, lien filing, or benefit reduction if they fail to understand coordination rules, report benefits accurately to both administrators, or structure claim timing strategically. The likelihood of successfully maximizing total benefits while remaining compliant with coordination requirements is medium to high when counsel proactively manages both claims, maintains transparent reporting between programs, and anticipates offset calculations at the point of settlement or final benefit determination.

II. LEGAL FRAMEWORK & STATUTORY AUTHORITY

A. Foundational Workers' Compensation Statutes

California's workers' compensation system operates under a statutory framework codified primarily in the California Labor Code, Division 4 (commencing with section 3200), and Division 5 (commencing with section 6300)[54]. The cornerstone principle is articulated in Labor Code Section 3200, which establishes that workers' compensation benefits are payable for all workers injured in the course and scope of their employment without regard to employer negligence or fault, thereby creating what is termed a "no-fault" system[70]. This foundational rule distinguishes workers' compensation from traditional tort litigation by eliminating the need for injured workers to prove negligence but simultaneously barring injured workers from suing their employers in civil court for damages arising from the injury[70].

The creation and calculation of temporary disability (TD) benefits is governed by Labor Code Section 4650, which mandates that payment of temporary disability indemnity shall be made "no later than 14 days after knowledge of the injury and disability" and continue at intervals of "not less frequently than once every two weeks, unless otherwise ordered by the appeals board."^[22] For injuries on or after January 1, 2025, the minimum temporary total disability rate is \$252.03 per week, while the maximum for 2025 is \$1,680.29 weekly.^{[3][34]} As of January 1, 2026, these rates increase to a minimum of \$264.61 and maximum of \$1,764.11 weekly, adjusted based on changes to the State Average Weekly Wage (SAWW).^{[34][37]} The calculation of temporary disability is uniformly expressed as two-thirds of the injured worker's average weekly wage (AWW), derived from the worker's earnings history preceding the injury, subject to these statutory minimum and maximum caps^{[14][22][38]}.

Permanent disability benefits, by contrast, are governed by Labor Code Section 4660-4664, which establish the framework for calculating impairment ratings using the American Medical Association Guides to the Evaluation of Permanent Impairment (5th Edition) and converting these ratings to disability percentages after adjustment for occupation, age, and future earning capacity.^{[11][11]} The maximum permanent disability payment an injured worker may receive is circumscribed by Labor Code Section 4664(c)(1), which establishes that "the accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662."^{[4][4]} This apportionment limitation creates significant complexity in cases involving multiple injuries affecting the same body region and has been substantially refined by recent Workers' Compensation Appeals Board decisions, most notably *Stranak v. City of Los Angeles* (2024), which placed the burden of proof on employers seeking to apply the apportionment statute and required that disability ratings affecting multiple body systems be assigned to the system generating the highest compensable rating.^{[4][4]}

Vocational rehabilitation benefits, now commonly referred to as Supplemental Job Displacement Benefits (SJDB), are provided under Labor Code Section 4658.5 et seq. and take the form of a non-transferable voucher issued when an injured worker reaches maximum medical improvement, becomes unable to return to their usual job, and the employer does not provide suitable alternative work at 85 percent or more of prior wages within 60 days of the physician's Permanent and Stationary (P&S) determination.^{[27][30]} For injuries occurring on or after January 1, 2013, the maximum SJDB voucher amount is \$6,000, which may be used for tuition, books, career guidance, equipment, and professional certification fees at state-approved educational institutions, with the voucher expiring two years from issuance or five years from date of injury, whichever is later.^{[27][30]}

B. State Disability Insurance Statutory Framework

State Disability Insurance operates under a distinct statutory architecture codified in the California Unemployment Insurance Code (commencing with section 3200 et seq.). Unlike workers' compensation, which covers work-related injuries exclusively, SDI provides benefits for non-work-related illness, injury, pregnancy, childbirth, and family leave under Labor Code Section 245 and related provisions.^{[6][10][10]} The program is funded through mandatory employee payroll contributions (1.3% as of 2025), and eligibility requires that the claimant have earned at least \$300 in wages during the base period (twelve months preceding the claim, specifically the twelve months ending five to eighteen months before disability begins), have been certified by a physician as unable to perform normal work duties, and be available for work when able.^{[6][15][15]}

Benefit amounts under SDI are calculated as a percentage of average weekly wages earned during the quarter of the base period in which earnings were highest.^{[15][15]} For claimants whose highest quarterly earnings range from \$722.50 to \$16,279.90 (representing annual earnings of approximately \$2,890 to \$65,119), the weekly benefit amount is approximately 90 percent of weekly wages.^[15] For higher earners, the calculation shifts to a different formula, with the maximum weekly benefit amount increasing to \$1,765 for 2025 and remaining at that statutory maximum for 2026.^{[6][64]} The maximum total benefit payable under SDI for any single claim is 52 weeks of benefits, though the duration may extend beyond 52 calendar weeks if the weekly benefit amount is reduced due to part-time work or other factors.^{[6][15]}

C. Coordination of Benefits Statutory Framework

The legal mechanism preventing simultaneous receipt of workers' compensation and SDI benefits derives from multiple statutory sources. Labor Code Section 4664 establishes the primary coordination principle by stating that if an applicant "has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury," thereby creating a basis for offset or apportionment.[4][9][10] However, the most direct coordination rule appears in Employment Development Department guidance and practice, which establishes that SDI "generally" does not apply when the worker is receiving workers' compensation for the same condition during the same time period.[10][10][10] This principle is reinforced by Labor Code Section 2629.1(f), which mandates that once a workers' compensation claim is accepted or a final award is issued, the employer must reimburse EDD within 60 days for any SDI benefits paid while the workers' comp claim was pending.[63]

When SDI is paid while a workers' compensation claim is under investigation or delayed, the EDD establishes and files a statutory lien against any future workers' compensation settlement or award.[1][10][10] The amount of the lien equals the total SDI benefits paid, and upon resolution of the workers' compensation claim (whether by settlement or award), the workers' compensation administrator or employer is obligated to reimburse EDD, which effectively reduces the injured worker's net recovery from workers' compensation by the amount of the SDI lien, unless the workers' compensation settlement specifically allocates funds for lien repayment separate from the gross award.[10][29][63] However, if the workers' compensation claim is ultimately denied, the SDI benefits remain the sole recovery and no repayment obligation arises.

D. Social Security Disability Insurance Offset Framework

When an injured worker receives both workers' compensation and federal Social Security Disability Insurance (SSDI), an additional offset mechanism applies under 42 U.S.C. Section 424a, which establishes that combined workers' compensation and SSDI benefits cannot exceed 80 percent of the worker's average current earnings (ACE).[23][25] This offset differs structurally from the California SDI coordination in that Social Security—not the workers' compensation system—applies the reduction. Specifically, the Social Security Administration reduces the beneficiary's SSDI payment so that the combined total of workers' compensation plus adjusted SSDI does not exceed the 80 percent threshold.[23][25] This creates a cascading coordination problem in complex cases: an injured worker might receive workers' compensation at the statutory maximum, then discover that their SSDI benefit is reduced by the offset, and simultaneously face EDD lien issues if SDI was paid during the pending period.[23][25]

III. CURRENT LEGAL LANDSCAPE & RECENT DEVELOPMENTS

A. Changes to Temporary Total Disability Rates (Effective January 1, 2026)

The Division of Workers' Compensation announced on November 21, 2025, that temporary total disability rates would increase effective January 1, 2026, based on a 4.988 percent increase in the State Average Weekly Wage (SAWW) from \$1,704 (2024) to \$1,789 (2025).[37] The minimum TTD rate increased from \$252.03 to \$264.61 weekly, while the maximum TTD rate increased from \$1,680.29 to \$1,764.11 weekly.[34][37] This adjustment affects all injured workers currently receiving TTD benefits on or after January 1, 2026, and those calculating TTD amounts for purposes of settlement or future benefit projections.[34][37] For workers receiving benefits 24 months or more from the date of injury, Labor Code Section 4661.5 mandates that TTD payments be recalculated using the TTD rate in effect at the time of payment rather than the rate at the time of injury, provided the updated calculation does not produce a lower payment.[41] This provision ensures that injured workers benefit from annual SAWW adjustments even if substantial time has elapsed since their injury.

B. Utilization Review Regulatory Changes (Effective April 1, 2026)

Effective April 1, 2026, updated utilization review regulations tighten timelines and documentation standards for approving, denying, or modifying medical treatment requests in workers' compensation cases.[40] These changes directly impact SDI coordination because delays in workers' compensation medical treatment authorization may trigger workers' compensation claim delays, which in turn may justify concurrent SDI filing.[40] The updated rules require faster decision-making (with stricter deadlines for responding to requests for authorization), impose higher standards for documentation of denial reasoning, and establish clearer appeals procedures.[43] A key practical implication is that injured workers and their counsel must now maintain more rigorous documentation of treatment requests, denials, and follow-up communications because incomplete records may be flagged sooner as grounds for denial, leaving fewer opportunities to cure defects

and potentially extending the initial claim investigation period during which SDI might bridge the gap.[40][43]

C. SSDI Offset Clarifications and COLA Adjustments

As of 2026, the federal Social Security Administration continues to apply the 80 percent offset rule to workers who receive both workers' compensation and SSDI.[23][25] No legislative change at the federal level has modified this offset rule, meaning injured workers must anticipate potential SSDI reduction when planning overall disability benefit strategy. Additionally, effective January 1 each year, Life Pension and Permanent Total Disability benefits receive annual Cost-of-Living Adjustment (COLA) increases based on the prior year's SAWW increase, ensuring that long-term beneficiaries maintain purchasing power.[66] Proposed legislation, specifically Senate Bill 555 (introduced March 27, 2025, by Senator Anna M. Caballero), would extend COLA adjustments to Permanent Partial Disability beneficiaries, though as of March 2026, this bill has not been enacted.[71] If enacted, SB 555 would significantly alter the value proposition of PPD settlements versus accepting ongoing PPD payments, as currently PPD amounts remain static while life pension and PTD receive annual increases.

D. San Francisco Immigration Court and Northern California Specific Guidance

While immigration law falls outside workers' compensation directly, Northern California's civil litigation landscape includes district courts (Northern District of California and Central District of California) that occasionally hear workers' compensation-related challenges to agency action, particularly when injured workers seek judicial review of WCAB decisions or challenge agency coordination of benefits determinations.[43] The San Francisco federal courts have jurisdiction over challenges to EDD overpayment determinations and other administrative agency actions affecting injured workers' benefits, making federal court review an important alternative remedy when state administrative remedies prove inadequate.[12][7] Recent unpublished decisions in the Ninth Circuit have addressed Service members' benefits coordination with workers' compensation, though these carry limited precedential value.[43]

IV. DISABILITY BENEFIT TYPES & ELIGIBILITY REQUIREMENTS

A. Workers' Compensation Temporary Disability Benefits

Temporary disability benefits under California workers' compensation constitute wage replacement paid to injured workers who are unable to perform their usual job duties while recovering from a work-related injury or illness.[14][22][24] Two distinct categories exist: Temporary Total Disability (TTD) and Temporary Partial Disability (TPD). Temporary Total Disability applies when an injured worker is completely unable to work due to the injury, whereas Temporary Partial Disability applies when the worker can perform some work but at reduced earnings due to work restrictions imposed by the treating physician.[14][24]

Eligibility for TTD requires several elements: (1) the worker must have suffered a work-related injury or illness "arising out of and in the course of employment";[70] (2) the worker must be medically certified by a physician as unable to perform their usual work;[14][22] (3) the worker must have reported the injury to their employer within 30 days of becoming aware of the work relationship (the notice requirement under Labor Code Section 5400);[17][58] and (4) the injury must have caused actual wage loss—that is, the worker is not being paid by the employer during the recovery period.[14] The three-day waiting period historically imposed before TTD becomes payable is waived if the disability extends beyond 14 days or if the worker is hospitalized.[14][24]

TTD is calculated as two-thirds of the injured worker's average weekly wage (AWW).[14][22][24][65] The AWW is determined using one of four statutory methods under Labor Code Section 4453, depending on the worker's employment circumstances: (1) for full-time, regularly employed workers, AWW is the daily wage multiplied by the number of working days per week; (2) for workers with multiple concurrent employers, AWW includes earnings from all jobs using a specific formula that caps the secondary employer wage at the defendant employer's rate; (3) for workers paid at irregular rates (commission, piecework), AWW is calculated by averaging actual weekly earnings over the 52 weeks preceding injury; and (4) a catch-all provision applies "where for any reason" the foregoing methods cannot reasonably apply, requiring the claims administrator to document all relevant factors and calculate a fair AWW under the circumstances.[41]

For workers with concurrent employment (multiple jobs at the time of injury), the coordination rule is that if the defendant employer pays the lower wage, the secondary employer's higher wage must be "stepped down" to the defendant's rate when calculating the combined AWW.[41][63] For example, if a worker earned \$25/hour for 20 hours weekly with the defendant employer and \$50/hour for 20 hours weekly with a secondary employer, the AWW calculation would treat all 40 hours at the defendant's \$25/hour rate, yielding \$1,000/week rather than \$1,500/week.[41][63] This rule significantly disadvantages workers with multiple employment and requires careful wage documentation to ensure compliance.

Maximum and minimum TTD rates are adjusted annually. For 2026, the minimum is \$264.61 weekly and the maximum is \$1,764.11 weekly.[34][37] These caps apply regardless of the injured worker's actual average weekly wage; an extremely high earner receives only the maximum, while a low-wage worker receives the full two-thirds calculation even if it would fall below the minimum.[14][38] The duration of TTD is limited to 104 weeks within a five-year period from the date of injury, with exceptions for severe injuries (up to 240 weeks) and specific catastrophic injury classifications.[14][22][70]

Temporary Partial Disability applies when an injured worker returns to work but is earning less than pre-injury wages due to work restrictions.[14][24][63] TPD is calculated as two-thirds of the "weekly loss in wages"-that is, two-thirds of the difference between pre-injury earnings and current reduced earnings.[14][24][63] Unlike TTD, TPD does not have a predetermined duration limit in the statute; rather, TPD continues as long as the worker's earnings remain reduced due to the work-related injury and the treating physician maintains work restrictions.[14][24]

B. Workers' Compensation Permanent Disability Benefits

Permanent Disability (PD) benefits are awarded once an injured worker's medical condition has stabilized and reached Maximum Medical Improvement (MMI)-that is, the point at which further medical treatment is unlikely to produce substantial improvement.[14][70] PD compensates the worker for lasting impairment that affects the worker's future earning capacity and non-economic losses, such as pain, disfigurement, or loss of enjoyment of life.[14] PD is not tied to whether the worker returns to work; an injured worker may be receiving full pre-injury wages but still qualify for PD if permanent restrictions limit their future employability.[14]

PD benefits are calculated using a three-step process. First, the treating physician or qualified medical evaluator assigns a Whole Person Impairment (WPI) rating using the AMA Guides, 5th Edition, describing the objective medical loss of function attributable to the injury.[11][14][11] Second, this WPI rating is converted to a "modified whole person impairment" by applying a statutory 1.4 multiplier for injuries on or after January 1, 2013, to account for loss of future earning capacity.[11][14][11] Third, this modified impairment is adjusted for the worker's occupation and age using the Permanent Disability Rating Schedule (PDRS) to arrive at a final disability percentage ranging from 1 to 100 percent.[11][14][11] The weekly PD benefit amount is determined by multiplying the disability percentage by the worker's average weekly earnings, subject to statutory minimum (\$160/week for injuries on or after January 1, 2014) and maximum (\$290/week) rates.[11][14][11]

The duration of PD payments depends on the disability rating.[65] Ratings of 1 to 69 percent receive Permanent Partial Disability (PPD) benefits paid over a fixed number of weeks, with higher ratings resulting in longer benefit periods.[11][14][11][65] Ratings of 70 to 99 percent receive PPD payments plus a subsequent Life Pension, which begins after PPD exhaustion and continues until the worker's death.[11][14][11][65] A rating of 100 percent qualifies the worker for Permanent Total Disability (PTD), which provides lifetime wage replacement at the TTD rate and lifetime medical care.[14][62][11][65]

Permanent Total Disability (PTD) is the most valuable benefit category in workers' compensation. To qualify, the worker must be unable to perform any gainful employment given the injury, age, occupation, and marketability in the labor market.[62] PTD can result from either a single catastrophic injury conclusively presumed total (such as loss of both hands, bilateral blindness, or paraplegia) under Labor Code Section 4662, or from a combination of injuries and impairments with a combined rating of 100 percent plus supporting medical and vocational evidence that the worker is unemployable.[14][62] PTD beneficiaries receive two-thirds of their average weekly wage (not the reduced minimum/maximum rates applicable to PPD) for the remainder of their lives, with annual COLA adjustments.[14][62][11][66]

C. State Disability Insurance Eligibility and Benefit Types

State Disability Insurance provides short-term wage replacement for non-work-related disability and is divided into two main benefit types: Disability Insurance (DI) and Paid Family Leave (PFL).[6][10] DI applies to workers unable to work due to non-work-related illness, injury, physical or mental disability, pregnancy, childbirth, or recovery from elective surgery.[6][10][10] PFL applies to workers taking time off to care for a seriously ill family member, bond with a new child, or participate in a qualifying military family event.[6]

Eligibility for SDI requires five threshold conditions: (1) the claimant must be a covered employee (generally, all private sector employees and many public sector employees in California are covered); (2) the claimant must have earned at least \$300 in wages during the base period and have paid SDI taxes on those wages (SDI contributions are withheld automatically, typically 1.3% of gross wages as of 2025);[64] (3) the claimant must be certified by a licensed physician as unable to perform their usual work due to the non-work-related condition;[6][15] (4) the claimant must have a medical condition that is medically substantiated and expected to last at least eight consecutive calendar days (with some exceptions for pregnancy or hospitalization, which require only one day);[6] and (5) for non-pregnancy claims, the claimant must be available to work when the condition improves, meaning the claimant intends to return to work and is not self-employed without employees, retired, or otherwise unavailable for employment.[6][15]

The "base period" for SDI purposes is the 12-month window used to calculate the claimant's highest quarterly earnings. For claims beginning on or after January 1, 2026, the base period is determined by the month the claim begins: if the claim begins in January, February, or March, the base period is October 1 of the prior year through September 30 of the current year; if the claim begins in October, November, or December, the base period is July 1 of the prior year through June 30 of the current year.[15][15] This structure means that a claimant's SDI eligibility and benefit amount depend on earnings history from 5 to 18 months prior to the claim start date, creating potential timing issues when comparing SDI eligibility to workers' compensation timing.

D. Medical Provider Networks and Choosing Treatment Providers

Both workers' compensation and SDI intersect with medical care access through distinct provider networks. For workers' compensation, if the employer has a Medical Provider Network (MPN), the injured worker must initially treat within the MPN unless an exception applies.[67][68][69] MPNs are employer/insurer-selected groups of physicians approved by the Division of Workers' Compensation to provide occupational medicine and must meet access standards: at least three physicians in each specialty within 30 minutes or 15 miles of the workplace, specialists within 60 minutes or 30 miles, and emergency services available 24/7.[67][68][69] After the first appointment, injured workers may change to another MPN physician; after the first chiropractic visit, chiropractic services are covered only up to 24 visits unless specific conditions justify extension.[68]

If no MPN exists, the claims administrator may designate a treating physician for the first 30 days, after which the injured worker may choose any reasonably available physician.[68] If the injured worker predesignated a personal physician before the injury, that physician becomes the primary treating physician immediately upon injury.[68] For SDI, by contrast, the claimant selects a treating physician without employer involvement; SDI does not impose a provider network requirement, allowing free choice of any licensed physician willing to treat the condition.[6][10]

V. COORDINATION RULES & OFFSET MECHANISMS

A. The "No Double-Dipping" Principle

The foundational rule governing coordination between workers' compensation and SDI is that an injured worker cannot receive full wage replacement benefits from both programs simultaneously for the same injury and time period.[1][3][10][10][10] This principle, commonly called the "no double-dipping" rule, rests on the policy that disability benefit programs are designed to replace lost wages, and receiving full replacement from two sources would overcompensate the worker beyond lost wages, creating a financial incentive to remain disabled rather than return to work.[1][3][10]

The mechanics of this coordination operate differently depending on claim timing and status. If a worker sustains a work-related injury and immediately reports it to the employer, the employer's workers' compensation insurance is the primary payor, and SDI does not apply while workers' compensation is active.[1][10][10][10] However, if the workers' compensation claim is delayed (the insurer has up to 90 days

to investigate and make a liability determination), denied, or the injured worker erroneously files for SDI not realizing the injury is work-related, SDI may be paid during the interim period.[1][10][10][10] In this scenario, once the workers' compensation claim is ultimately resolved (accepted and benefits begin, or denied), a different interaction rule applies.

B. The SDI Lien and Recovery Mechanism

When SDI benefits are paid while a workers' compensation claim is pending or under investigation, the EDD is subrogated to recover those benefits once the workers' compensation claim is resolved.[1][10][10][10][63] Specifically, Labor Code Section 2629.1(f) mandates that within 60 days of the workers' compensation claim being accepted (liability determined in the injured worker's favor) or a final award being issued by the Workers' Compensation Appeals Board, the employer or claims administrator must reimburse EDD for the full amount of SDI paid.[63] This reimbursement obligation is automatic and does not require the injured worker's consent; it operates as a statutory lien against the workers' compensation recovery.[1][10][10][10]

The practical effect is that an injured worker who received \$5,000 in SDI benefits while awaiting workers' compensation acceptance will find that the \$5,000 is deducted from their gross workers' compensation award, reducing net recovery.[1][10][10][10] However, the workers' compensation settlement or award should specifically account for the EDD lien. If properly structured, the settlement documents show a gross award (before lien deduction) and a net award (after lien deduction), and the claims administrator pays both the worker's net amount and the EDD lien repayment directly to EDD.[1][10][10][10][29]

The EDD lien applies only to the extent that SDI benefits were paid for the same condition and overlapping time period as workers' compensation.[1][10][10] If the workers' compensation claim is ultimately denied (the insurer determines the injury is not work-related), the SDI benefits remain permanent, and no lien arises because workers' compensation did not provide benefits to offset.[10][10][10] Additionally, if SDI is paid for a portion of the disability period and workers' compensation for a different portion or different injury, the coordination is limited to the overlapping period.[1][10][10]

C. The Supplemental Payment Exception

An exception to the strict no-double-dipping rule exists when the SDI weekly benefit amount exceeds the workers' compensation temporary disability weekly benefit amount.[1][3][10][10] In this scenario, the injured worker is entitled to receive the workers' compensation benefit plus a supplemental amount from SDI up to the difference between the two rates.[1][3][10][10][3][10] This provision acknowledges that SDI's 70-90 percent replacement may exceed workers' compensation's fixed two-thirds rate when the workers' compensation rate is reduced due to statutory minimums or the injured worker's earnings structure.

For example, if an injured worker's TTD benefit under workers' compensation is \$400/week but the SDI rate is \$600/week, the worker receives the \$400 workers' compensation benefit plus a supplemental \$200 SDI payment (total \$600), which equals the higher SDI rate.[1][3][10][10][3] If the workers' compensation rate later increases (e.g., after two years, the rate is recalculated and increases to \$500/week), the SDI supplement is reduced to maintain a combined total of \$600/week.[1][10][10]

This supplemental exception is particularly relevant for workers with lower average weekly earnings, who are more likely to hit the statutory minimum TTD rate (currently \$264.61/week for 2026) while potentially qualifying for higher SDI rates.[1][3][10][10][34]

D. The Difference Payment Scenario

A related scenario arises when the workers' compensation rate is lower than the injured worker's usual weekly earnings, and the worker obtains part-time work that does not fully replace lost wages. In this situation, a Temporary Partial Disability (TPD) calculation applies: the worker receives (2/3 x wage loss), where wage loss equals the difference between pre-injury earnings and current reduced earnings.[14][24][63]

If SDI is also being paid, the coordination requires that SDI and TPD together not exceed the workers' compensation rate for full TTD (two-thirds of AWW). This creates a complex offset calculation that requires careful tracking of all payments and coordination between the claims administrator and EDD.[1][10][10][10]

E. Strategic Timing: Avoiding Unintended Lien Exposure

The lien recovery mechanism creates incentives for strategic claim timing. An injured worker who is uncertain whether an injury is work-related faces a choice: file for workers' compensation and risk being denied (triggering reimbursement obligations if SDI was paid) or file for SDI and risk discovering the injury is work-related later (when the workers' compensation recovery will be reduced by the SDI lien).

From a risk management perspective, the safest approach is to file for workers' compensation first, even if there is ambiguity about work-relatedness, because if the claim is ultimately accepted, SDI payments (if any were made) are recovered, but if the claim is denied, the worker retains the SDI benefits without obligation.^{[1][10][10][58]} However, this approach requires that the injured worker have sufficient savings to bridge any gap between the date the injury occurs and when workers' compensation benefits begin (typically 14 days after the employer receives notice, per Labor Code Section 4650^{[22][17]}).

Counsel should advise clients to report injuries to employers immediately and in writing to satisfy the 30-day notice requirement under Labor Code Section 5400, regardless of initial uncertainty about work-relatedness.^{[17][58]} Once reported, the employer must provide medical treatment up to \$10,000 while the claim is under investigation, so deferring medical care is not necessary and delays evidence gathering.^[17]

VI. CALCULATION METHODOLOGIES & BENEFIT AMOUNTS

A. Average Weekly Wage (AWW) Calculation for Workers' Compensation

The Average Weekly Wage is the linchpin for all workers' compensation wage-replacement benefits and is calculated using one of four statutory methods under Labor Code Section 4453 and California Code of Regulations Section 10101.1.^{[38][41][63]} The choice of method depends on the worker's employment circumstances at the time of injury.

Method 1: Regular Full-Time Employment

For workers employed on a regular basis at 30 hours or more per week and five or more days per week, the AWW is calculated by multiplying the daily wage (gross hourly rate x hours per day) by the number of working days per week.^{[38][41]} For example, if a worker earned \$25/hour and worked 8-hour shifts five days per week, the calculation is: $\$25 \times 8 \text{ hours} \times 5 \text{ days} = \$1,000/\text{week AWW}$.^{[38][41]}

Method 2: Multiple Concurrent Employers

For workers with concurrent employment at the time of injury (multiple jobs), the AWW includes earnings from all employers, but with a critical limitation: if the defendant employer (the employer against whom the claim is filed) pays a lower hourly rate than secondary employers, the secondary employers' wages are "stepped down" to the defendant's rate.^{[38][41][63]} This rule applies the defendant's rate across all hours worked, preventing the use of secondary employment to inflate the AWW calculation.

Critically, if the defendant employer pays the highest rate, the secondary employer wages are calculated at the defendant's rate, not the secondary employer's actual rate.^{[41][63]} For instance, if Employer A (defendant) pays \$25/hour, Employer B pays \$30/hour, and the worker works 20 hours/week at each employer, the AWW is calculated using the lower rate: $\$25 \times (20+20) = \$1,000/\text{week}$, not $\$25 \times 20 + \$30 \times 20 = \$1,100/\text{week}$.^{[38][41][63]} This "stepping down" approach has been consistently upheld by California courts despite controversy and produces significantly lower AWW (and thus lower benefits) for workers with multiple employment.

Method 3: Irregular Earnings (Commission, Piecework, Seasonal Work)

For workers paid on irregular bases-commission, piecework, or seasonal employment-the AWW is calculated by totaling actual earnings over the 52 weeks preceding the injury and dividing by 52.^{[38][41]} This method accounts for periodic employment and variable earnings. If a worker has worked fewer than 52 weeks, the calculation uses the actual number of weeks worked, divided by the number of weeks to establish an annualized rate.^{[38][41]} For instance, if a seasonal worker earned \$10,000 in six months (26 weeks), the AWW is $\$10,000 / 26 = \$385/\text{week}$, then annualized to $\$385 \times 52/26$ (adjusting for seasonal pattern), yielding approximately \$385/week for TTD purposes.^{[38][41]}

Method 4: The Catch-All Provision

When none of the foregoing methods "reasonably and fairly" apply, California Code of Regulations Section 10101.1(j)(4) requires the claims administrator to document all relevant factors and calculate AWW in a manner that "most equitably and justly" reflects the worker's earning capacity.[38][41] Courts have interpreted this broadly to permit consideration of earning capacity even when the worker was temporarily unemployed, recently hired, about to be promoted, or working reduced hours due to disability or seasonal patterns.[38][41] This catch-all method is discretionary but must be documented and is subject to appeal if deemed unreasonable.[38][41]

B. Temporary Disability (TTD) Benefit Calculation and 2026 Rates

Temporary disability benefits are universally calculated as two-thirds (66.67%) of the worker's Average Weekly Wage, subject to statutory minimum and maximum rates that adjust annually based on the State Average Weekly Wage (SAWW).[14][22][24][38][65]

Formula: $TTD = (AWW \times 2/3)$, subject to minimum and maximum

For 2026:

Minimum TTD: \$264.61/week

Maximum TTD: \$1,764.11/week[34][37]

Recalculation After Two Years:

Importantly, Labor Code Section 4661.5 provides that if TTD payments are made 24 months or more after the date of injury, the payment must be calculated using the TTD minimum and maximum rates in effect at the time of payment, not at the time of injury, provided this does not result in a lower payment.[38][41] This means an injured worker receiving TTD in year three or beyond may see an increase if the annual SAWW adjustment has increased the statutory maximum, even if their AWW has not changed.[38][41]

2025 TTD Rates (for comparison):

Minimum: \$252.03/week

Maximum: \$1,680.29/week[3][34][38]

The increase from 2025 to 2026 reflects the 4.988 percent SAWW adjustment, which applies across all SAWW-indexed benefits.[34][37]

C. Permanent Disability (PD) Rating and Calculation

Permanent Disability benefits flow from a three-step process: (1) assignment of Whole Person Impairment (WPI) rating per AMA Guides 5th Edition; (2) conversion to modified whole person impairment by applying the statutory 1.4 multiplier (for injuries on or after January 1, 2013); and (3) adjustment for age and occupation using the Permanent Disability Rating Schedule to yield final disability percentage and weekly benefit amount.[11][14][11][65]

Weekly PD Benefit = Disability % x AWW, subject to minimum (\$160/week) and maximum (\$290/week) (for injuries on or after January 1, 2014)[11][14][11]

Duration of PD Payments:

1-4% disability: 2 weeks

5% disability: 3 weeks

10% disability: 6 weeks

25% disability: 15 weeks

50% disability: 35 weeks

75% disability: 58 weeks

99% disability: 88 weeks

100% disability: Permanent Total Disability (lifetime payments)[11][14][11][65]

The duration table reflects a nonlinear relationship: the number of weeks payable increases exponentially as disability ratings approach 100 percent, reflecting the theory that higher disability ratings represent greater impact on future earning capacity and thus warrant longer benefit periods.[11][14][11][65]

D. State Disability Insurance (SDI) Benefit Calculation and 2025-2026 Rates

SDI benefits are calculated as a percentage of average weekly wages earned in the highest-earning quarter of the base period, subject to minimum and maximum limits.[6][15][15][64]

SDI Calculation by Income Tier (2025):

Lowest tier (annual earnings \$1,200-\$2,889.96): \$50/week minimum

Mid-tier (annual earnings \$2,890-\$65,119.60): 90% of average weekly wages

Upper-mid-tier (annual earnings \$65,119.64-\$83,725.20): \$1,127/week fixed

Highest tier (annual earnings over \$83,725.24): 70% of average weekly wages, up to \$1,765 maximum[15][15]

For 2026: The maximum weekly SDI benefit remains \$1,765 (unchanged from 2025 due to statutory caps), though the formulas for each income tier are applied to 2026 earnings history.[6][64]

Duration: SDI benefits are paid for a maximum of 52 weeks per claim, though the actual duration may extend beyond 52 calendar weeks if benefits are reduced due to part-time work or other part-time earnings.[6][15][15]

E. Concurrent Receipt and Offset Calculations

When both workers' compensation and SDI are paid for overlapping periods, the offset calculation requires tracking the weekly rate of each benefit and ensuring combined payments do not exceed the higher of the two rates (except in specific supplemental scenarios).[1][3][10][10][3]

Standard Offset: If Benefit A = \$400/week and Benefit B = \$600/week, the injured worker receives Benefit B (\$600/week) and Benefit A is offset to \$0.

Supplemental Payment: If the programs determine supplemental payment is appropriate (e.g., SDI exceeds TTD), combined payments equal the higher rate. If TTD = \$400/week and SDI = \$600/week with supplemental provision, total = \$600/week (\$400 WC + \$200 SDI supplement).

Overpayment Calculation: If an injured worker erroneously received \$400/week in TTD and \$600/week in SDI simultaneously (total \$1,000/week) when only one benefit applied or offset should have reduced the total, an overpayment of \$400/week accrues. The overpaying program (typically SDI) establishes a recovery obligation, and the injured worker must repay or allow future benefits to be offset to recover the overpayment.[7][12][7]

VII. NORTHERN CALIFORNIA IMPLEMENTATION SPECIFICS

A. San Francisco Division of Workers' Compensation Local Procedures

The Northern California workers' compensation system is administered through several Division of Workers' Compensation district offices, with the primary San Francisco offices located at 100 Montgomery Street, Suite 800, and 630 Sansome Street, 4th Floor, both in San Francisco.[35] A satellite location serves the Concord area (1855 Gateway Blvd., Suite 850, Concord) to accommodate claimants in the East Bay.[35] These offices handle claim filing, hearing scheduling, and adjudication of disputes for the five-county Northern California region.

Northern California workers' compensation judges, particularly those sitting in San Francisco, have developed distinct procedural tendencies that sophisticated counsel must understand. The San Francisco court generally favors early continuances for evidence gathering, requires detailed written motions rather than oral motion practice, and demonstrates receptiveness to expert medical evidence when properly presented in the form of declaration or live testimony.[35] The court also maintains a mandatory settlement conference (MSC)

requirement before trial, during which judges actively facilitate settlement discussions and assess the strength of each party's evidence on liability and benefit calculation issues.[20]

B. San Francisco Asylum Office Procedures and SDI Interaction

While immigration asylum falls outside workers' compensation, the San Francisco Asylum Office processes disability-related claims that may intersect with workers' compensation. Injured workers seeking asylum or SSDI benefits while pursuing workers' compensation claims face coordination issues with SDI, particularly regarding work authorization requirements and benefit continuation during pending immigration proceedings. These intersection points, though specialized, are relevant for the immigrant worker population served in Northern California.

C. Northern California ICE ERO Field Office and Detention Issues

The ICE Enforcement and Removal Operations (ERO) Field Office 1, based in San Francisco, maintains capacity and enforcement priorities affecting injured immigrants potentially in removal proceedings while pursuing workers' compensation claims. Injured workers detained by ICE may have limited ability to attend medical appointments, workers' compensation hearings, or appear before QMEs, creating serious procedural complications. California's sanctuary law (SB 54, the California Values Act) limits ICE cooperation with state agencies and prevents most state employees from assisting ICE enforcement, but does not shield injured workers from federal immigration enforcement.[35]

D. Northern District of California and Central District of California Jurisdictional Considerations

Federal courts in Northern California (United States District Court for the Northern District of California, based in San Francisco) occasionally hear workers' compensation-related claims when injured workers seek judicial review of WCAB decisions under the Administrative Procedure Act (APA) or bring Section 1983 civil rights claims against state officials. The Ninth Circuit, which controls appellate review of NDCal decisions, has published certain unpublished decisions on workers' compensation offset calculations and benefit coordination, though these carry limited precedential value and are cited primarily for persuasive authority.[43]

Federal court review of state workers' compensation determinations is available only in narrow circumstances: when WCAB decisions conflict with federal constitutional requirements, when statutory interpretation involves federal law questions, or when agency action violates the APA.[43] Injured workers should pursue state administrative remedies (WCAB petition for reconsideration, appeal to Workers' Compensation Appeals Board, then Court of Appeal petition for writ of review) before seeking federal court review, as federal courts generally require exhaustion of state remedies.[43]

E. California State Court Rules and COVID-Era Remote Proceeding Protocols

As of 2026, California state courts (including the Workers' Compensation Appeals Board) continue to offer remote appearance options for hearings and conferences, a protocol that began during COVID-19 and has been retained in the rules of court.[19] Injured workers attending mandatory settlement conferences or hearings from outside the San Francisco area may appear remotely via video, reducing travel burden and costs. However, in-person examination by a Qualified Medical Evaluator (QME) remains required; remote QME examinations are permitted only in limited circumstances and generally require the QME's office to be equipped for secure telehealth.[59]

VIII. STRATEGIC FILING & TIMING CONSIDERATIONS

A. The Initial Report Decision: Workers' Compensation vs. SDI

When an injured worker first becomes disabled, the worker faces a critical decision: report the injury to the employer as a workers' compensation claim, or file for SDI? This decision carries lasting consequences for benefit amounts, timing, and overpayment risk.

Factors Favoring Immediate Workers' Compensation Report: (1) Workers' compensation provides comprehensive medical coverage (all reasonable and necessary treatment) without the worker bearing costs, whereas SDI provides only wage replacement and the worker must secure non-occupational medical care through private insurance or pay out-of-pocket;[1][10][14][68] (2) Workers' compensation rates, once set, do

not vary based on subsequent earnings, whereas SDI rates depend on earnings history and may be lower for new workers or those with recent earnings gaps;[1][6][10][10] (3) Once workers' compensation is reported and initially investigated, the 90-day investigation period provides a known timeline, after which the claim is presumed accepted if no denial is issued, eliminating uncertainty;[17][58] (4) Workers' compensation's TTD minimum rate (\$264.61 for 2026) may exceed SDI minimum for low-wage workers, and the two-thirds calculation is higher than SDI's 70-90 percent for some income levels.[1][3][10][10][34][38][64]

Factors Creating SDI Filing Incentive: (1) If the injury is clearly not work-related (e.g., appendicitis, off-work illness), SDI is the only applicable program and delay in SDI filing reduces total benefits (SDI benefits are not retroactive before the claim start date);[6][10] (2) If the work-relatedness is genuinely ambiguous and the worker faces a significant time gap before workers' compensation is accepted or potentially denied, SDI provides a safety net during investigation;[1][10][10][10] (3) In rare cases, SDI's 90 percent replacement rate may exceed workers' compensation's two-thirds rate when the worker's average weekly earnings are in a high bracket where SDI's 90 percent threshold applies.[6][15]; (4) SDI imposes no occupational classification restriction, whereas workers' compensation may impose work restrictions limiting the injured worker's job duties even if medically capable of performing some work.[14]

Optimal Strategy:

From a comprehensive benefits-maximization perspective, counsel should advise clients to report any potentially work-related injury to the employer immediately and in writing, thereby satisfying the 30-day notice requirement and triggering both the employer's investigation obligation and the 14-day payment obligation under Labor Code Section 4650.[17][22][58] This report does not preclude later SDI filing if workers' compensation is denied; it establishes a record of early notice, which strengthens the workers' compensation claim and triggers the employer's medical treatment obligation.[17][68]

Simultaneously, if the work-relatedness is genuinely uncertain, counsel may advise filing for SDI within a reasonable period (within weeks of disability onset) to preserve SDI eligibility and begin wage replacement while workers' compensation is investigated.[1][10][10][10] If workers' compensation is subsequently accepted, any SDI payments can be recovered through the EDD lien mechanism.[1][10][10][10] If workers' compensation is denied, the SDI payments remain and no lien arises.[10][10][10]

This dual-filing approach requires careful coordination: counsel must ensure that both the workers' compensation claim form and any SDI filing mention the other benefit to prevent claims examiners and EDD from making determinations in isolation.[1][10][10][10]

B. Timing Relative to Maximum Medical Improvement and Settlement

The point at which an injured worker reaches Maximum Medical Improvement (MMI)-also called Permanent and Stationary (P&S)-triggers significant downstream consequences for both workers' compensation and potential SDI continuation.[14][70]

When the treating physician declares the injured worker P&S, the following events typically occur: (1) TTD benefits cease (the worker is no longer "temporarily" disabled);[14][22] (2) the claims administrator requests a Permanent Disability evaluation from the treating physician or a Qualified Medical Evaluator;[14][56][57][59] (3) PD ratings and payment schedules are calculated;[14][11]; and (4) vocational rehabilitation eligibility (Supplemental Job Displacement Benefit) is determined.[27][30]

From an SDI perspective, if the injured worker's condition is not work-related, SDI may continue beyond the P&S date if the worker remains unable to perform normal work and has not exhausted the 52-week maximum.[6][15][10] However, if the injury was work-related and workers' compensation has accepted liability and issued PD benefits, SDI must cease.[1][10][10] The strategic timing consideration is whether to delay or accelerate the P&S determination to maximize total benefits from both programs.

Scenario: An injured worker received TTD for 80 weeks and then the treating physician declares P&S. Under workers' compensation, PD benefits are calculated based on the impairment rating. Simultaneously, if SDI is being paid (perhaps due to a prior workers' compensation claim delay), the P&S date signals that SDI should cease because workers' compensation is now the primary payor. If the worker had reached the SDI 52-week maximum just before P&S, no SDI discontinuation occurs (the worker already exhausted benefits). If the

worker had only received 20 weeks of SDI and the P&S date arrives at week 30 of SDI eligibility, SDI payments cease, and the worker transitions to PD payments.

Counsel should coordinate with the treating physician and QME to ensure P&S determinations are made at strategically optimal times, particularly when SDI supplemental payments are in effect or when the timing affects settlement calculations.

C. Pre-Settlement Disclosure and EDD Lien Calculation

Before settling a workers' compensation claim, counsel must obtain an EDD lien statement from the EDD showing the exact amount of SDI benefits paid during any overlapping period.^{[1][10][10][29]} This statement becomes a line item in the settlement agreement's allocation of funds. Failure to account for the EDD lien or to properly reimburse EDD can result in post-settlement liability, as the employer retains the obligation to reimburse EDD within 60 days of settlement.^{[1][10][10][63]}

The settlement document should explicitly state the gross award (before lien deduction), the EDD lien amount, the net award to the injured worker, and the separate payment to EDD.^{[1][10][10][29]} This clear allocation ensures that all parties understand the division of funds and prevents the injured worker from incorrectly believing they have retained the full gross award amount.

IX. OVERPAYMENT, RECOVERY & REPAYMENT OBLIGATIONS

A. Sources of Overpayment: Duplicate Benefits and Calculation Errors

Overpayments arise from several distinct sources, each triggering different recovery and repayment mechanisms:

Duplicate Simultaneous Payments: An injured worker receives full TTD from workers' compensation (\$400/week) and full SDI (\$600/week) for the same condition and overlapping period, totaling \$1,000/week when only one program should have paid or offset should have reduced the total. This creates an overpayment of \$400-\$600/week depending on the coordination rule.^{[1][3][10][10][3][10]}

Calculation Errors: The claims administrator miscalculates AWW, applies an incorrect TTD rate, or fails to adjust benefits after statutory rate changes, resulting in underpayment of the correct benefit. Upon correction, the injured worker receives a back-payment adjustment, not an overpayment. Conversely, if the claims administrator overstates AWW or applies an inflated rate, correction creates an overpayment obligation.^{[41][63][64]}

Continued Payment After Returning to Work: A claims administrator continues TTD payments after the injured worker has returned to work full-time, failing to switch the claim to TPD or terminate TTD benefits. This creates overpayment equal to the difference between TTD received and the actual TTD owed (which should be \$0 if working full-time).^{[14][22][63]}

Failure to Apply Wage Loss Offsets: An injured worker working part-time receives both part-time wages and full TPD benefits, when the actual TPD calculation should yield \$0 or reduced TPD based on actual wage loss. This results in overpayment of TPD.^{[14][24][63]}

EDD/Workers' Compensation Coordination Failure: SDI is paid during a workers' compensation delay period, but the SDI rate calculation uses incorrect wage history or the workers' compensation claim is subsequently denied, triggering a lien repayment obligation that was not anticipated in the SDI payment. This creates overpayment at the SDI level, or at the workers' compensation level if WC paid simultaneously with uncorrected SDI.^{[1][10][10][10]}

B. EDD Overpayment Procedures and Waiver Process

When the EDD determines that SDI benefits were overpaid, the EDD sends a "Notice of Potential Overpayment" along with a "Personal Financial Statement" (Form DE 1446).^{[7][7]} The injured worker has the opportunity to complete and return the Personal Financial Statement to request an overpayment waiver, which the EDD grants only if repayment would cause "extraordinary hardship."^{[7][7]} If the overpayment is determined to be non-fraudulent (i.e., not intentionally caused by the worker's misrepresentation), the EDD may waive part or all of the overpayment if the injured worker meets the extraordinary hardship standard.^{[7][7]}

If the overpayment is not waived, the injured worker must repay through several mechanisms: (1) lump-sum payment by check, money order, or credit/debit card through ACI Payments Inc. (which charges a fee);[7][7] (2) ongoing benefit offset, whereby 25 percent of future unemployment, disability, or PFL benefits are withheld to recover overpayment (for non-fraud overpayments) or 100 percent for fraud overpayments;[7][12][7] (3) tax refund offset, whereby the EDD withholds federal and state tax refunds to recover overpayment;[7][7] (4) state lottery winnings offset;[7][7] or (5) litigation by the EDD seeking summary judgment in superior court for recovery of the overpaid amount plus interest and court costs.[7][12][7]

The Waiver Process:

If no Personal Financial Statement is provided with the initial overpayment notice, the injured worker cannot request a waiver.[7][7] Once the overpayment determination is final (after any appeal), the EDD sends a "Benefit Overpayment Collection Notice" (Form DE 8344JUDR) with the Claimant ID and Letter ID required for repayment.[7][12][7]

Appeals Process:

An injured worker who disagrees with an overpayment determination must file an appeal in writing within 30 days of the mailed date of the notice.[7][7] The appeal should be mailed to the address shown on the overpayment notice and should state the reasons why the worker disputes the overpayment finding.[7][7] An Administrative Law Judge (ALJ) at the California Unemployment Insurance Appeals Board (CUIAB) reviews the appeal and issues a decision within a reasonable time frame.[7][12][7] If the ALJ approves the appeal, the overpayment determination is reversed and no repayment is owed. If the appeal is denied, the injured worker must repay or allow ongoing benefit offset.[7][7]

C. Workers' Compensation Overpayment Procedures

Workers' compensation overpayments are handled differently. The claims administrator may issue a "Delay Notice" stopping payment of benefits if an overpayment is discovered, or may file a "Petition for Credit for Overpayment" with the Workers' Compensation Appeals Board seeking to reduce future benefits or awards by the overpayment amount.[63] If the injured worker is still receiving Temporary Partial Disability (wage loss) benefits while the overpayment is discovered, the wage loss benefit can be credited against the overpayment to reduce the total recovery obligation.[63]

The injured worker may contest the overpayment calculation through a workers' compensation hearing before a Workers' Compensation Judge (WCJ), where both the claims administrator and the injured worker present evidence regarding the calculation, timing, and appropriateness of correcting for overpayment.[63] The WCJ may approve the overpayment petition, deny it, or modify the overpayment amount based on the evidence.[63]

D. Penalties for Late Reporting and Misrepresentation

If an injured worker intentionally misrepresents earnings, work status, or medical condition to obtain duplicative benefits from both workers' compensation and SDI, both programs impose penalties above and beyond the overpayment recovery obligation.[7][12][7][50][73]

EDD Penalties:

The EDD imposes a "penalty assessment" equal to 30 percent of the fraud overpayment amount (in addition to the full repayment of the overpaid benefit).[7][7] This penalty is assessed by EDD and can be litigated only in superior court. The injured worker has no right to appeal a penalty assessment within the EDD administrative process; the only recourse is civil litigation.[7][7]

Workers' Compensation Penalties:

Labor Code Section 5814 allows workers' compensation penalties for unreasonable delay or refusal to pay benefits; however, this section contemplates penalties against claims administrators, not injured workers. Conversely, if an injured worker makes a false statement under penalty of perjury in a workers' compensation claim form or related document, the injured worker may face criminal prosecution for perjury or fraud under California Penal Code SectionSection 118, 148, or 550.[17][58]

X. APPEALS, DISPUTE RESOLUTION & REMEDIES

A. EDD Administrative Appeal Process

An injured worker who disagrees with an EDD overpayment determination, disqualification for SDI benefits, or disputed benefit calculation has the right to request a hearing before an Administrative Law Judge (ALJ) at the California Unemployment Insurance Appeals Board (CUIAB).[7][12][7] The request must be filed in writing within 30 days of the mailed date of the notice being appealed.[7][7] The appeal may be submitted by mail, by email to the address specified on the notice, or through the myEDD online account.[7][7]

The ALJ hearing is typically conducted by telephone or video conference (as of 2026) and includes both the injured worker (or their representative) and an EDD representative.[7][7] The injured worker bears the burden of proving that the EDD's determination is incorrect, by presenting evidence of earnings, work status, medical condition, or other facts relevant to the appeal.[7][7]

If the ALJ rules in favor of the injured worker, the EDD's determination is reversed, benefits are restored, and no overpayment is owed (or the overpayment is waived if already assessed).[7][7] If the ALJ rules against the injured worker, the determination stands and the injured worker must repay the overpayment or allow ongoing benefit offset unless further appeal is pursued.[7][7]

Further Appeal:

An injured worker may appeal the ALJ's decision to the California Unemployment Insurance Appeals Board (CUIAB) within 30 days of the ALJ decision's mailing date, but CUIAB review is limited to legal questions (whether the ALJ correctly interpreted and applied the law) and does not revisit factual findings unless there is "clear and convincing evidence" that the ALJ's findings are erroneous.[7][7] CUIAB's decision is final, though judicial review via writ of mandate is available in superior court to challenge legal errors.[7][12][7]

B. Workers' Compensation Appeals Board Process

An injured worker who disagrees with a Workers' Compensation Judge's (WCJ) decision may file a "Petition for Reconsideration" with the Workers' Compensation Appeals Board (WCAB) within 20 working days of the WCJ's decision.[19][20] The petition must state the specific grounds for reconsideration and must identify the issues the board should address.[19][20] The WCAB will grant or deny the petition within a reasonable time frame; if granted, the board may affirm, modify, or reverse the WCJ's decision.[19][20]

If the WCAB denies the petition for reconsideration or the injured worker disagrees with the WCAB's decision, the injured worker may file a "Petition for Writ of Review" with the Court of Appeal within 30 days of the WCAB decision's circulation date.[19][20] The Court of Appeal reviews the WCAB's decision for legal errors and may affirm, reverse, or modify the decision based on the law.[19][20] The Court of Appeal does not revisit factual findings unless they are wholly lacking in substantial evidence support.[19][20]

C. Independent Medical Review (IMR) for Utilization Review Disputes

When a claims administrator denies or modifies a medical treatment request through utilization review, the injured worker has the right to request Independent Medical Review (IMR) through the Division of Workers' Compensation.[45][46][48] An IMR request must be filed within 30 days of the utilization review decision's service date, using the official DWC Form IMR-1, and must be mailed to the designated independent medical review organization (IMRO).[45][46][48]

The IMR process is conducted by a physician reviewer unaffiliated with the claims administrator, who reviews the medical records, the treating physician's request, and the claims administrator's utilization review decision to determine whether the treatment is medically necessary.[45][46][48] The reviewer issues a binding determination within a specified timeframe (typically 14 days for expedited review, 30 days for standard review).[45][46][48] If the reviewer determines the treatment is medically necessary, the claims administrator is ordered to authorize and pay for the treatment within five business days.[45][46][48] If the reviewer determines the treatment is not medically necessary, the utilization review denial stands.[45][46][48]

An injured worker may appeal an unfavorable IMR determination by filing a petition with the WCAB within 30 days of the final determination's mailing date.[45][46] The grounds for appeal are limited to clear and convincing evidence that the reviewer was subject to material conflict of interest, bias, or fraud, or made a

plainly erroneous mistake of fact.[45][46] The IMR determination is presumed correct and the WCAB cannot substitute its medical judgment for the reviewer's independent medical judgment.[45][46]

XI. MEDICAL & VOCATIONAL COMPONENTS

A. Qualified Medical Evaluators (QMEs) and Role in Benefit Determination

When there is a dispute about medical causation, severity, or disability rating between the injured worker's treating physician and the claims administrator, the dispute is resolved through a Qualified Medical Evaluator (QME) evaluation.[56][57][59] A QME is a licensed physician who meets additional educational and licensing requirements, passes a state examination on workers' compensation evaluation standards, and participates in ongoing continuing education on the workers' compensation system.[56][57][59] QMEs are selected from a state-certified panel specific to the injured worker's injury and geographic location, using a random computer selection process managed by the Division of Workers' Compensation Medical Unit.[56][57][59]

An injured worker has the right to select one QME from the panel list within 10 days of the panel's issuance.[59] If the injured worker fails to select within 10 days, the claims administrator may select on behalf of the injured worker.[59] The injured worker may request a replacement panel if the selected QME is unavailable to schedule an appointment within 90 days (extended to 120 days if the injured worker agrees to wait).[56][59]

The QME examination is independent and impartial; the QME is not the injured worker's treating physician and should have no prior treatment relationship with the injured worker (except limited exceptions for prior treatment of unrelated conditions).[56][59] The QME reviews medical records, conducts a physical examination, and prepares a written report addressing the specific medical issues in dispute (causation, degree of permanent impairment, restrictions, future medical needs).[56][57][59]

The QME's report is submitted to both the injured worker and the claims administrator and becomes a key piece of evidence in determining permanent disability ratings and future medical care entitlement.[56][57][59][65] If the injured worker's treating physician and the QME disagree on disability rating, the Workers' Compensation Judge must decide which opinion is more credible and supported by substantial medical evidence; California law does not automatically prefer either opinion.[56][57]

B. Vocational Experts and Supplemental Job Displacement Benefits

When an injured worker reaches Maximum Medical Improvement and is permanently unable to return to the usual job, the claims administrator must determine vocational rehabilitation eligibility and SJDB voucher entitlement.[27][30][30] A vocational expert or rehabilitation counselor may evaluate the injured worker's residual functional capacity, education, work experience, and labor market availability to determine whether the worker can compete for suitable work within restrictions imposed by the work-related injury.[27][30][30]

If the vocational expert determines that the injured worker cannot perform the usual job and no suitable alternative work is available (either from the employer at 85+ percent of prior wages or in the open labor market), the injured worker qualifies for an SJDB voucher worth up to \$6,000.[27][30][30] The voucher is non-transferable and must be used within two years of issuance or five years of injury, whichever is later, for educational retraining or skill enhancement at state-approved schools.[27][30][30]

Additionally, for injuries on or after January 1, 2013, injured workers who receive an SJDB voucher and have "disproportionately low" permanent disability ratings relative to actual earnings loss may qualify for the Return-to-Work Supplement Program (RTWSP), a one-time \$5,000 payment from a state-funded account.[28][31][30] Eligibility requires application through the online RTWSP portal within one year of SJDB voucher issuance.[28][31]

C. Maximum Medical Improvement and Treating Physician Role

The treating physician plays the critical role in declaring that an injured worker has reached Maximum Medical Improvement (MMI), at which point further medical treatment is unlikely to produce substantial objective improvement.[14][70] The physician's P&S (Permanent and Stationary) report triggers the transition from temporary to permanent benefits and initiates the permanent disability evaluation process.[14][70]

The timing of the P&S declaration has strategic importance for SDI coordination: once P&S is declared, TTD benefits cease and PD benefits begin. If SDI has been paid during the TTD period, the SDI lien becomes enforceable at the point workers' compensation issues final PD payments or settlement.[1][10][10][10]

XII. INTERACTION WITH OTHER BENEFIT PROGRAMS

A. Social Security Disability Insurance (SSDI) Offset Coordination

When an injured worker receives both workers' compensation and federal Social Security Disability Insurance (SSDI), the Social Security Administration applies a "workers' compensation offset" under 42 U.S.C. Section 424a.[23][25] This offset operates independently of California's SDI coordination rules and reduces the injured worker's SSDI benefit to ensure combined benefits do not exceed 80 percent of average current earnings (ACE).[23][25]

The ACE is defined as the highest of (1) the average monthly wage on which the SSDI primary insurance amount (PIA) is based, (2) average monthly earnings from covered employment during the highest 5 consecutive years after 1950, or (3) average monthly earnings during the highest 12 consecutive months in the period of time the worker was working.[23][25] Once the offset is calculated, the Social Security Administration reduces the injured worker's SSDI payment dollar-for-dollar until combined benefits equal the 80 percent threshold.[23][25]

Example:

Pre-disability monthly earnings: \$5,000

80% of pre-disability earnings: \$4,000

Workers' compensation monthly benefit: \$2,500

SSDI monthly benefit (before offset): \$2,200

Combined: $\$2,500 + \$2,200 = \$4,700$ (exceeds \$4,000 cap)

SSDI offset: $\$4,700 - \$4,000 = \$700$

Adjusted SSDI: $\$2,200 - \$700 = \$1,500$

Final combined: $\$2,500 \text{ WC} + \$1,500 \text{ SSDI} = \$4,000$ [23][25]

The offset is applied before offsets for dependent benefits; if the injured worker has dependents receiving SSDI family benefits, those benefits are reduced before the worker's own benefit is offset.[23][25]

B. Medicare Coordination and Medicare Set-Asides

For workers' compensation claimants who receive SSDI and thus become eligible for Medicare at age 65 (or after 24 months of SSDI receipt), Medicare becomes the primary payer for medical services related to the work injury if the workers' compensation settlement has closed (deemed final) the future medical care component.[10][10][10] Settlements that explicitly reserve future medical care (called "stips with future medical") do not trigger Medicare as primary; rather, the workers' compensation system retains the obligation to pay for future medical care related to the injury.[21]

However, if a workers' compensation settlement includes a lump-sum allocation for future medical costs (called a "Compromise and Release" or C&R settlement), Medicare Set-Aside (MSA) rules may apply.[18][29] The MSA process requires that a portion of the settlement lump sum be set aside to fund future medical treatment for the work injury to the extent Medicare would not cover it.[18][29] This protects Medicare from having to pay for injury-related care when workers' compensation settlement funds are available.[18][29]

C. Workers' Compensation and Unemployment Insurance

An injured worker receiving TTD benefits is generally not eligible for Unemployment Insurance (UI) because the TTD benefit is predicated on being unable to work, whereas UI requires the worker to be able and available for work.[1][10][10] However, if an injured worker returns to work part-time and is receiving TPD benefits, the worker may qualify for partial UI benefits if total earnings (TPD + part-time wages) fall below

the statewide average weekly wage, creating "insufficient earnings" for a particular week, which allows the worker to file a UI claim for that week.[1][10][10][10]

This intersection creates a fourth coordination rule beyond WC/SDI/SSDI: the combination of WC benefits and UI benefits must be tracked to ensure the injured worker is not receiving wage replacement in excess of lost wages for any given week.[1][10][10]

D. Charitable Benefits and Employer-Provided Assistance

Some injured workers have access to charitable benefits, union strike funds, or employer-provided short-term disability insurance (STD). These benefits are coordinated differently from government programs.[1][3][10][10][3]

Employer-Provided Short-Term Disability:

If an injured worker's employer provides private STD coverage, the policy typically includes an offset provision that coordinates STD with workers' compensation.[3][3] The offset usually operates such that if the injured worker receives \$400/week in workers' compensation, the STD payment is reduced by \$400, so combined total approaches but does not exceed the full benefit.[3][3]

Charitable Benefits:

Charitable grants to injured workers are generally not counted as "income" or "benefits" for purposes of coordination rules and do not trigger offset or repayment obligations. However, counsel should review the specific terms of any charitable program to confirm it does not require repayment from workers' compensation settlements.[1][10][10]

XIII. RISK ASSESSMENT & CLIENT DECISION FRAMEWORK

A. Qualitative Risk Factors in Dual-Benefit Scenarios

When an injured worker faces a choice between workers' compensation and SDI, or is considering timing of benefit claims relative to one another, several qualitative risk factors warrant assessment:

Work-Relatedness Uncertainty (Medium-to-High Risk)

If the injury's work-relatedness is ambiguous (e.g., a flare-up of a pre-existing condition triggered by work, or an illness contracted in the workplace but not caused by work), the injured worker faces the risk of workers' compensation denial and concurrent lien obligation if SDI was paid during investigation. Conversely, failure to assert a colorable workers' compensation claim preserves SDI eligibility but may foreclose workers' compensation entirely if the statute of limitations (one year from date of injury) passes without filing.[58][61]

Risk Mitigation: Report the injury to the employer in writing immediately, thereby preserving the option to pursue workers' compensation while protecting SDI filing rights if workers' compensation is later denied.[17][58][61] The cost of erring on the side of reporting is minimal (the employer investigates and denies if not work-related, or accepts if work-related), whereas the cost of failing to report forecloses workers' compensation entirely.[17][58][61]

Benefit Rate Disparity (Low-to-Medium Risk)

If SDI's 90 percent replacement rate exceeds workers' compensation's two-thirds rate for a particular worker's earnings level, the injured worker may receive lower total benefits by claiming workers' compensation first and foregoing SDI supplementation. Conversely, if workers' compensation's two-thirds rate is higher, claiming workers' compensation yields more income.[1][3][10][10][3][38]

Risk Mitigation: Calculate both scenarios (WC-only and SDI-only) using the injured worker's actual earnings history and 2026 benefit rates before filing either claim, and base the decision on which benefit yields higher wage replacement.[1][3][10][10][34][38]

Medical Coverage Gaps (Medium Risk)

SDI provides only wage replacement; it does not cover medical treatment, whereas workers' compensation covers all reasonable and necessary occupational medical care.[1][6][10][14][10][68] If an injured worker

files for SDI first and later discovers workers' compensation should have been pursued, medical bills from the interim period may not be covered by either program (SDI does not pay medical, and workers' compensation may be denied if the injury is ultimately found non-work-related).[1][10][10]

Risk Mitigation: Ensure injured workers file for workers' compensation first when any work-relatedness is plausible, to preserve comprehensive medical coverage during the investigation period.[1][10][14][10][17]

B. Settlement and Lien Considerations

Before settling a workers' compensation claim, counsel must account for potential EDD lien obligations. The EDD lien reduces the net settlement amount the injured worker receives, requiring strategic decision-making about settlement timing and structure.

Lien Amount Calculation:

The lien equals the total SDI benefits paid during the overlapping period (from claim start date through workers' compensation acceptance or final award).[1][10][10][29] If \$10,000 in SDI was paid during a 20-week investigation period before workers' compensation acceptance, the EDD lien is \$10,000, which reduces the injured worker's net recovery from the workers' compensation settlement by \$10,000.[1][10][10][29]

Settlement Structure Options:

(1) Net Settlement to Worker; Gross Lien Payment to EDD: The settlement document specifies a gross award (e.g., \$50,000), deducts the EDD lien (e.g., \$10,000), and pays the injured worker \$40,000 net, with the claims administrator paying the \$10,000 directly to EDD. This structure is transparent and compliant with Labor Code Section 2629.1(f).[1][10][10][63]

(2) Lien Repayment as Separate Item: In some settlements, the injured worker negotiates for the claims administrator or employer to pay the EDD lien as a "make-whole" addition to the settlement, leaving the injured worker with the full settlement amount despite the lien obligation. This requires employer/insurer agreement and typically applies only when the injured worker disputes the claim-triggering event or when the employer seeks to resolve the case quickly.[1][10][10]

(3) Delayed Lien Repayment: The settlement specifies that the injured worker receives the full net amount initially, and the claims administrator pays the EDD lien separately within 60 days of settlement approval. This structure is permissible under Labor Code Section 2629.1(f) as long as EDD is repaid within the statutory timeframe.[1][10][10][63]

Best Practice:

Counsel should obtain an EDD lien letter from the EDD before finalizing any settlement, providing the exact amount owed and the claim date and period of SDI payments. This documentation ensures the settlement adequately accounts for the lien and prevents post-settlement disputes.[1][10][10][29]

C. Overpayment and Repayment Risk Management

Injured workers who are uncertain whether an injury is work-related and file for both workers' compensation and SDI simultaneously face elevated overpayment risk. If both programs pay the injured worker simultaneously, the overpayment accrues immediately; neither program automatically reduces the other, relying instead on post-payment reconciliation.[1][3][10][10][3]

Risk Mitigation:

(1) Transparent Reporting: When filing for SDI, explicitly disclose any pending workers' compensation claim and the injury date/description so the EDD knows to coordinate benefits and anticipate potential offset.[1][10][10][10]

(2) Proactive Overpayment Monitoring: Request regular benefit statements from both the claims administrator and EDD showing all payments made to date. Cross-check payment amounts and dates to identify any periods of duplicate payments before the injured worker actually receives both payments simultaneously.[1][10][10][10]

(3) Lump-Sum Coordination: Do not accept lump-sum benefit payments from either program without understanding how the payment accounts for concurrent benefits from the other program. If SDI offers a settlement amount without mentioning the pending workers' compensation claim, question whether the SDI amount already reflects offset or is the full grossed-up amount subject to future reduction.[1][10][10][10]

XIV. APPENDICES & COMPLETE CITATIONS

Appendix A: Relevant California Labor Code Sections (Full Text Excerpts)

Labor Code Section 3200 (Injury Defined)

Text omitted for space; full statutory text available at [<https://www.law.cornell.edu/uscode/text/8/3200> and California Legislative Information website]

Labor Code Section 4650 (Timing of Temporary Disability Payments)

(a) If the injury causes temporary disability, payment of temporary disability indemnity shall be made no later than 14 days after knowledge of the injury and disability, and shall continue not less frequently than once every two weeks, unless otherwise ordered by the appeals board.[22]

Labor Code Section 4653 (Limitation on Temporary Disability Duration)

The aggregate amount of weekly benefits payable to an employee for temporary total disability shall not exceed 104 weeks within a period of five years from the date of injury.[14][22]

Labor Code Section 4664 (Cumulative Disability - Lifetime Limitation)

(c)(1) The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662.[4][9]

Labor Code Section 5400 (Injury Report Requirement)

Notice of the injury shall be given to the employer within 30 days from the date of the injury.[17][58]

Labor Code Section 5405 (Claim Filing Statute of Limitations)

Claims for compensation must be filed within one year from the date of injury.[58][61]

Labor Code Section 2629.1(f) (EDD Lien Repayment Obligation)

Employers must reimburse EDD within 60 days of accepting liability or receiving a final award.[63]

Appendix B: California Code of Regulations

Cal. Code Regs. Tit. 8 Section 10101.1 (Average Weekly Wage Calculation)

(j)(4) Where none of the foregoing methods of arriving at the average weekly earnings can reasonably and fairly be applied, the average weekly earnings shall be determined by dividing the total earnings during 12 months prior to the date of injury by the number of weeks the employee actually worked during that period, excluding any weeks during which no wages were earned.[41]

Cal. Code Regs. Tit. 8 Section 9792.10.1 (Utilization Review Dispute Resolution)

(a) If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute shall be resolved in accordance with Labor Code sections 4610.5 and 4610.6.[46]

Appendix C: Key Case Holdings

Stranak v. City of Los Angeles (2024)

2024 Cal. Wrk. Comp. P.D. LEXIS 179. Established that when a disability impacts multiple body systems under Labor Code Section 4664(c)(1), it should be assigned to the body system generating the highest rating. Employer bears burden of proving apportionment.[4][4]

Russell v. WCAB (2021)

86 CCC 1011 (writ denied). Applied Section 4664(c)(1) to reduce employee's award from 100% to 66% where prior award was rated within the "catch-all" provision and new injury was in same body region.[4][4]

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